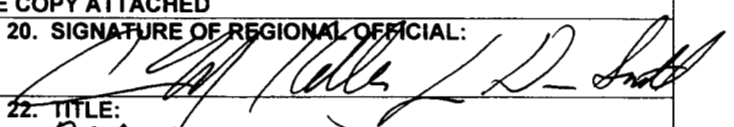


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 0 4 - 0 1 2	2. STATE: CO
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2004	
5. TYPE OF PLAN MATERIAL (<i>Check one</i>):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS A NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: CFR 42 Section 447.253		7. FEDERAL BUDGET IMPACT: a. FFY 2004 \$ <u>-\$3.8 Million</u> b. FFY 2005 \$ <u>-\$11.5 Million</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19A Pages 11, 17, 21-22, 27-39		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>if applicable</i>): Attachment 4.19A Pages 11, 17, 21-22, 27-37	
10. SUBJECT OF AMENDMENT: Modifications to DSH and Medicaid Payments for SFY 2005			
11. GOVERNOR'S REVIEW (<i>Check One</i>):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER AS SPECIFIED Governor's letter dated July 1, 2003 <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: Marilyn Golden		Colorado Department of Health Care Policy and Financing 1570 Grant Denver, Colorado 80203 Attn: Trish Bohm	
14. TITLE: Director, Operations and Finance Office			
15. DATE SUBMITTED: August 18, 2004			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: AUG 18 2004		18. DATE APPROVED: DEC 15 2004	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2004		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Carmen Keller		22. TITLE: DCN Deputy Director, CMSO	
23. REMARKS:			

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II. Family Medicine Program

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies as a Teaching Hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Family Medicine Commission and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the Major Teaching Hospital program, it is not eligible for this program. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Program will be \$213,195. Effective July 1, 1999, the annual payment for each Family Medicine Residency Program will be \$228,379. The annual payment shall change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

The Family Medicine Residency Program payment is calculated on a State Fiscal Year (July 1 through June 30) basis and is distributed equally to all qualified providers in 12 equal monthly installments. Payments will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology.

Total funds available for this payment equal:

State Fiscal Year 2003-04	\$1,524,626
State Fiscal Year 2004-05	\$1,524,626

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The funds available for the Low-Income Shortfall payment under the Disproportionate Share Hospital Allotment are limited by the regulations set by and federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for this payment equal:

State Fiscal Year 2003-04	\$915,460
State Fiscal Year 2004-05	\$13,060

C. Colorado determination of Individual Hospital Disproportionate Payment Adjustment Associated with the Colorado Indigent Care Program and Bad Debt.

1. Effective July 1, 1993 Component 1 shall be superseded by a Disproportionate Share Adjustment payment method (herein described as Component 1a) which shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, disproportionate Share Hospital Adjustments, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:
 - a. Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Programs reimbursements.

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8. Effective from September 1, 2000, through September 30, 2000, each government hospital will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of \$79 million in Federal Fiscal Year 2000. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any government disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)). Effective June 1, 2001, this bad debt Disproportionate Share Adjustment payment to government hospitals is extended to an annual basis, and is subject to the Federal Funds limits of the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The limit for 2001 is \$81.765 million.
9. Effective July 1, 2003 the Bad Debt Disproportionate Share Adjustment payment to government hospitals is modified as follows and is commonly referred to as the "Bad Debt payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed as an annual payment prior to June 30 of each state fiscal year. This payment is available to non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals whose percent of Medicaid days relative to total days equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association.

As required by federal regulations the sum of this payment, the Low-Income Shortfall payment and the Low-Income payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The Bad Debt payment is only made if there is available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment and the Low-Income payment.

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The amount of available federal funds remaining under the Disproportionate Share Hospital allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt Costs for qualified providers. Available Bad Debt charges are converted to Bad Debt costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - Denver as of July.

Available funds under the Disproportionate Share Hospital Allotment are multiplied by the percentage resulting from dividing the hospital specific Bad Debt costs by the sum of all Bad Debt costs for qualified providers to calculate the Bad Debt payment for the specific provider. As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific Bad Debts costs.

The funds available for the Bad Debt payment under the Medicare Disproportionate Share Hospital Allotment are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for this payment equal:

State Fiscal Year 2003-04	\$4,538,380
State Fiscal Year 2004-05	\$1,516,570

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If the provider does qualify, then the Disproportionate Share Hospital Factor will equal the provider's specific percent of Medicaid days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Disproportionate Share Hospital Factor is equal to the provider's specific percent of Medicaid days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of the Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services. If the provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.

- ii. Medically Indigent Factor. To qualify for the Medically Indigent Factor, the provider's percent of medically indigent days relative to total inpatient days must equal or exceed the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.

If the provider does qualify, then the Medically Indigent Factor equals the provider specific percent of medically indigent days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Medically Indigent Factor is equal to the provider's specific percent of medically indigent days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government

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hospitals, the Medically Indigent Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services. If the provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.

There will be two allotments for the Low-Income payment: state owned government hospitals plus non-state owned government hospitals, and privately owned hospitals. For state-owned government hospitals plus non-state owned government hospitals, the allotment is the available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment, while for privately owned hospitals the allotment is further limited by the level of General Fund established and amended by the General Assembly.

The available allotments under the Disproportionate Share Hospital Allotment are multiplied by the hospital specific Weighted Medically Indigent Costs divided by the summation of all Weighted Medically Indigent Costs for qualified providers in each specific allotment to calculate the Low-Income payment for the specific provider. As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific Medically Indigent costs.

For this section, Medicaid days, medically indigent days and total inpatient days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

As required by federal regulations the sum of this payment and the Low-Income Shortfall payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The Low-Income payment is made only if there is available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment.

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The funds available for the Low-Income payment under the Medicare Disproportionate Share Hospital Allotment are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for this payment equal:

State Fiscal Year 2003-04	\$163,061,100
State Fiscal Year 2004-05	\$171,854,300

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II. MEDICARE UPPER PAYMENT LIMIT

- A. Effective July 1, 2001, non-state owned Government hospitals will receive additional Medicaid reimbursement up to the allowable percentage of each hospital's inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The payment will be calculated based on each hospital's inpatient Medicare base rate multiplied by the allowable Medicare Upper Payment Limit percentage, less the Medicaid base rate, times the Medicaid case mix index times the number of Medicaid discharges. In no case will the payment plus the Medicaid reimbursement exceed the funds appropriated by the Colorado General Assembly in the fiscal year for which the payments are made. Additional payments made to Government Outstate Disproportionate Share Hospitals which participate in the Colorado Indigent Care Program as defined in Attachment 4.19A (subsection Disproportionate Share Hospital Adjustments) will reduce the Disproportionate Share Hospital payments to these Government Outstate Disproportionate Share hospitals by an equal amount. Effective July 1, 2003 the payment described in this section is suspended.
- B. Colorado Determination of Individual Hospital Inpatient Medicare Upper Payment Limit Addition Reimbursement who Participate in the Colorado Indigent Care Program
1. Effective July 1, 2003 state owned government hospitals, non-state owned government hospitals and privately owned hospitals, which participate in the Colorado Indigent Care Program, will qualify to receive additional Medicaid reimbursement, such that the total of all payments will not exceed the inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "High-Volume payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

As required by federal regulations, there will be three allotments of the High-Volume payment: state owned government hospitals, non-state owned government hospitals and privately owned hospitals. In no case will the High-Volume payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment exceed any of these allotments. The High-Volume payment is only made if there is available federal financial participation under these allotments after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment. The High-Volume payment calculation process is outlined as follows:

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Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio (as calculated from the audited Medicare/Medicaid cost report [CMS 2552]) available as of March 1 each fiscal year. Medically indigent costs are inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - Denver as of July.

- a. The request budget year medically indigent costs are weighted (increased) by the following factors to measure the relative Medicaid and low-income care to the total care provided. Each provider's specific medically indigent costs are inflated (increased) by the following factors:
 - i. Percent of Medicaid (fee-for-service and managed care) days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.
 - ii. Percent of medically indigent days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.
- b. The request budget year provider specific medically indigent costs are weighted (increased) by the following factors, if they qualify, to account for disproportionately high volumes of Medicaid and low-income care provided. If the provider qualifies, the provider specific medically indigent costs are further inflated (increased) by the following factors:

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